III. BACKGROUND ON U.S. HOSPITALS AND PRIOR STUDIES

A. Background on U.S. Hospitals

According to the American Hospital Association (AHA), there are 5,708 registered hospitals in the United States.[6] These include 4,897 community hospitals, which are defined as all nonfederal, short-term general, and other special hospitals (obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services).[7] The community hospitals include the following:

- 2,913 nongovernment nonprofit community hospitals (59% of community hospitals)
- 873 investor-owned for-profit community hospitals (18% of community hospitals)
- 1,111 state and local government community hospitals (23% of community hospitals).[8]

AHA reports 1,997 rural community hospitals (41%) and 2,900 urban community hospitals (59%).[9] In its 2006 report on community benefit, the Congressional Budget Office reported that 51% of nonprofit hospitals were in large urban areas, 34% were in small urban or suburban areas, and 14% were in rural areas.[10]

According to the Congressional Budget Office, the distribution of hospitals across nonprofits, for-profits and government hospitals "varies markedly by region. In the Northeast, 89 percent of the hospitals are nonprofits, whereas in the South only 43 percent of the hospitals are nonprofits. For-profit hospitals are common in the South and West, but not in the Northeast and Midwest."[11] This is consistent with the 2005 GAO report, which reported that "states in the Northeast

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[6] http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html (Fast Facts on US Hospitals). The information from AHA's web site was as last updated on November 7, 2008. For this purpose, a registered hospital is a hospital that satisfies AHA's criteria for registration as a hospital facility, including both AHA member hospitals and nonmember hospitals.

[7] The remaining 811 non-community hospitals include federal government hospitals, nonfederal psychiatric hospitals, nonfederal long term care hospitals, prison hospitals, college infirmaries, and other facilities.

[8] This breakdown is similar to that reported by the Congressional Budget Office (CBO) in 2006: nonprofit hospitals (58%), for-profit hospitals (18%), and government hospitals (24%). Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006, pages 12-13 (Tables 2 and 3). It is also similar to the breakdown reported in the 2005 United States Government Accountability Office (GAO) report, "Nonprofit, For-Profit, and Government Hospitals, Uncompensated Care and Other Community Benefits," May 2005, page 4 (nonprofit hospitals – 62%, government hospitals – 20%, and for-profit hospitals – 18%).

[9] The AHA fact sheet did not describe how the hospitals were classified as rural or urban.

[10] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006, page 13.

[11] Id. at 12.

and Midwest had relatively high concentrations of nonprofit hospitals, whereas in the South the concentration was relatively low."[12]

The 2006 CBO study also reported the following, based on data from 2003:[13]

- Nonprofit hospitals tend to be larger than for-profit hospitals and are more likely to be teaching hospitals
- Nonprofit hospitals have higher average total assets, fixed assets, net patient revenues, and operating expenses than both for-profit and government hospitals
- Nonprofit hospitals have a total margin (3.9%), measured as total payments from all sources over all costs as a share of payments, that is somewhat higher than government hospitals (2.9%) but lower than for-profits (9.1%)

Critical Access Hospitals. The Medicare Rural Hospital Flexibility Program, created by Congress in 1997, allows certain hospitals to be licensed as critical access hospitals. Critical access hospitals generally must be located in a rural area or in an area treated as rural, and satisfy certain specified requirements allowing them to be designated as such.[14] Under federal law, critical access hospitals differ from urban and other rural hospitals, both in terms of how they are reimbursed under Medicare programs and in their organization and operations.

As of September 2008, there were 1,294 critical access hospitals in 45 states across the United States.[15] The five states with the greatest number of critical access hospitals were Kansas (83), Iowa (82), Minnesota (79), Texas (74), and Nebraska (65). Three heavily populated states – California (27), Florida (11), and New York (13) – have fewer critical access hospitals. Five states – Connecticut, Delaware, Maryland, New Jersey, and Rhode Island – did not participate in federal programs required for critical access designation and did not have any critical access hospitals in their states.

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[12] United States Government Accountability Office (GAO) report, "Nonprofit, For-Profit, and Government Hospitals, Uncompensated Care and Other Community Benefits," May 2005, page 4.

[13] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006, pages 12-14.

[14] See Section II.C for a description of the requirements for critical access hospital designation.

[15] www.flexmonitoring.org/cahlistRA.cgi (CAH Information). The information described here is as reported by the Flex Monitoring Team, which consists of the Rural Health Research Centers at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. The team members are recipients of a cooperative agreement award from the Federal Office of Rural Health Policy to monitor and evaluate the Medicare Rural Hospital Flexibility Program. The monitoring project assesses the impact of the flexibility program on rural hospitals and communities and the role of states in achieving overall program objectives, including improving access to and the quality of health care services; improving the financial performance of critical access hospitals; and engaging rural communities in health care system development.

Unlike other hospitals which are reimbursed under the Medicare prospective payment system, critical access hospitals receive cost-based reimbursement for inpatient and outpatient care. These differences may affect financial performance, and the incentives, financial management, and utilization practices under the two Medicare payment methods may differ substantially.[16]

The Flex Monitoring Team (see footnote 15 for an explanation of the Flex Monitoring Team) reviews 20 financial indicators in six domains – profitability, liquidity, capital structure, revenue, cost, and utilization – and prepares annual reports regarding these indicators for critical access hospitals across the United States. For example, in its August 2008 report (for 2006), the team reported a "total margin" (net income divided by total revenue) of 3.6% for critical access hospitals across the United States;[17] the total margin reported in the team's August 2007 report (for 2005) was 2.6%.[18] Profitability varied materially across the states – for 2005, critical access hospitals in 7 states had aggregate negative "total margins" and 4 states reported total margins exceeding 5% of total revenue.[19] For 2006, 4 states reported aggregate negative total margins, and 14 states reported total margins exceeding 5% of total revenue.[20] The Flex Monitoring Team reports demonstrate that financial performance for critical access hospitals varies considerably across the various states.

B. Other Studies on Community Benefit Provided by Nonprofit Hospitals

Other recent studies have explored community benefit reporting by nonprofit and other hospitals. These studies include a 2006 study by the Congressional Budget Office,[21] and two separate studies by the Government Accountability Office – one in 2005[22] and the other in 2008.[23] As described below, these studies generally found that community benefit reporting varied by type of hospital, and that uncompensated care and community benefit expenditures often were concentrated in a relatively small number of hospitals, whether nonprofit, for-profit, or government hospitals.

2005 GAO Report. In May 2005, the GAO issued a report to the Committee on Ways and Means, House of Representatives of the United States Congress,

[16] Flex Monitoring Team Data Summary Report No. 5, "CAH Financial Indicators Report: Summary of Indicator Medians by State," August 2008, page 2.
[17] Id. at 4.
[18] Flex Monitoring Team Data Summary Report No. 4, "CAH Financial Indicators Report: Summary of Indicator Medians by State," August 2007, page 4.
[19] Id.
[20] Flex Monitoring Team Data Summary Report No. 5, "CAH Financial Indicators Report: Summary of Indicator Medians by State," August 2008, page 4.
[21] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006.
[22] United States Government Accountability Office (GAO) report, "Nonprofit, For-Profit, and Government Hospitals, Uncompensated Care and Other Community Benefits," May 2005.
[23] United States Government Accountability Office (GAO) report, "Nonprofit Hospitals, Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," September 2008.

regarding uncompensated care and other community benefits provided by nonprofit, for-profit and government hospitals. The study looked at data from 5 states – California, Florida, Georgia, Indiana, and Texas. The study defined community benefits to include uncompensated care as well as services such as the provision of health education and medical research. GAO found that government hospitals generally devoted substantially larger shares of their patient operating expenses to uncompensated care (defined to include charity care and bad debt) than did nonprofit and for-profit hospitals.[24] Further, within each group, the burden of uncompensated care costs was not evenly distributed among hospitals but instead was concentrated in a small number of hospitals, meaning that a small number of nonprofit hospitals accounted for substantially more of the uncompensated care than did other nonprofit hospitals.[25] For all three groups, the top quarter of hospitals devoted substantially greater percentages of their patient operating expenses to uncompensated care, on average, compared with the bottom quarter of hospitals.[26]

2006 Congressional Budget Office Report. This study measured the provision of certain community benefits and compared nonprofit hospitals with for-profit hospitals. It also examined the provision of community benefits by nonfederal government hospitals.

The 2006 CBO Report found that although nonprofit hospitals must provide community benefits in order to receive tax exemptions, there is little consensus on what constitutes a community benefit or how to measure such benefits.[27] CBO found that, on average, nonprofit hospitals provided higher levels of uncompensated care (for purposes of this study, the sum of charity care and bad debt) than did otherwise similar for-profit hospitals, but that among individual hospitals, the provision of uncompensated care varied widely.[28] Uncompensated care as a share of hospitals' operating expenses was much higher at government hospitals (13.0%) than at either nonprofit hospitals (4.7%) or for-profit hospitals (4.2%).[29]

CBO also found that nonprofit hospitals were more likely than for-profit hospitals to provide certain specialized services that have been identified by certain

[24] United States Government Accountability Office (GAO) report, "Nonprofit, For-Profit, and Government Hospitals, Uncompensated Care and Other Community Benefits," May 2005 (What GAO Found).
[25] Id.
[26] Id. at 13-14.
[27] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006, page 1.
[28] Id. at 1-2. CBO observed that uncompensated care, when measured by including bad debt, has "substantial limitations" as a measure of community benefits, as it does not distinguish between the provision of charity care for the indigent and bad debt. Id. at 9.
[29] Id. at 2.

researchers as being generally unprofitable, including emergency room care, labor and delivery services, burn intensive care, and high-level trauma care.[30]

2008 GAO Report. In September 2008, the GAO issued its Report to the Ranking Member, Committee on Finance, U.S. Senate, regarding community benefit reporting by nonprofit hospitals.[31] In this study, GAO analyzed federal and state laws; the standards and guidance from federal agencies and industry groups; and 2006 data from California, Indiana, Massachusetts, and Texas. GAO found that the IRS's community benefit standard allows nonprofit hospitals broad latitude to determine the services and activities that constitute community benefit, and that state community benefit requirements that hospitals must meet to qualify for state tax-exempt or nonprofit status vary substantially in scope and detail.[32] GAO found that variations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report, and that nonprofit hospitals measure costs of these activities differently, which can lead to inconsistencies in reported community benefits.[33]

C. Study on Executive Compensation of Nonprofit Hospitals

2006 GAO Nonprofit Hospital System Survey on Executive Compensation Policies and Practices. In response to a request by the House Ways and Means Committee, the GAO surveyed executive compensation issues at selected private, nonprofit hospital systems to gain an understanding of the policies and practices related to the salaries, benefits, travel, gifts and entertainment expenses paid by these hospital systems.[34] The study's key questions were as follows:

- What corporate governance structure do selected hospital systems report as having in place over executive compensation?
- What is the basis for the compensation and benefits earned by, awarded to, or paid to the executives as reported by selected hospital systems?
- What internal controls do selected hospital systems report as having in place over the approval, payment, and monitoring of executive travel and entertainment expenses, gifts, and other perquisites?[35]

The GAO found that the hospital systems reported similarities in certain governance and compensation policies and practices, such as:

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[30] Id. at 3, 20.
[31] United States Government Accountability Office (GAO) report, "Nonprofit Hospitals, Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," September 2008.
[32] Id. (see What GAO Found).
[33] Id.
[34] United States Government Accountability Office, Nonprofit Hospital Systems, Survey on Executive Compensation Policies and Practices, June 2006.
[35] Id. at 1.

- having an executive compensation committee or entire board with primary responsibility for approving executives' base salary, bonuses, and perquisites;
- having a conflict of interest policy that covers members of the executive compensation committee and compensation consultants; and
- relying upon comparable market data of total compensation and benefits prior to making compensation determinations.[36]

The GAO found, however, that the hospital systems reported a range of practices with respect to entertainment, travel expenses, payment for perquisites such as memberships in recreational and social clubs, and audits of perquisites and entertainment expenses.[37]

[36] Id. at 2.
[37] Id.